

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4647

CERTIFICATE OF DEATH

64610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henderson		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital									
3. NAME OF DECEASED (Type or print)	First Deane	Middle Lerey	Last Barcus	4. DATE OF DEATH 4/20/1960	Month 4	Day 20	Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/86	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James T. Barcus		14. MOTHER'S MAIDEN NAME Emma Dean							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 20 0864		17. INFORMANT Adelaide Barcus, wife		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT (THROMBOSIS) INTERVAL BETWEEN DUE TO 5 DAYS Conditions, if any, which goe rise to immediate cause (a), stating the under- lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) PULMONARY EMPHYSEMA, PNEUMONIA, UREMIA									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED p. m. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPTEMBER 5, 1960 to 4/20/1960 that I last saw the deceased alive on 4/20/1960 , and that death occurred at 5:25 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE J. Kent Young M.D. 105 CHESTERFIELD AVE. PHYSICIAN'S NAME (Type) J. KENT YOUNG ADDRESS CENTREVILLE, MD. DATE SIGNED 4/21/60		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/23/60		22c. NAME OF CEMETERY OR CREMATORIAL Centreville		22d. LOCATION (City, town, or county) Centreville (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Clara L. Lane Chuck Hill		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4654

CERTIFICATE OF DEATH

64611

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY KENT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETTERTON		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BETTERTON	
3. NAME OF DECEASED (Type or print) MARY MYRTLE BECK		First MARY	Middle MYRTLE
4. DATE OF DEATH APRIL 14 1960	Month APRIL	Day 14	Year 1960
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 10 1889
9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) BALTIMORE, Md	12. CITIZEN OF WHAT COUNTRY U.S. A.
13. FATHER'S NAME PHILLIP M. PADGETT	14. MOTHER'S MAIDEN NAME ANNABELLE FLOWERS	Address HUSBAND Wm HENRY BECK, BETTERTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Wm HENRY BECK, BETTERTON	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. ① CARDIO-RENA) HYPERTENSIVE DISEASE 4 yrs	
		DUE TO ② CEREBRO-VASCULAR ACCIDENTS 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from NOV 1955 , 19 60 , to APRIL 13 , 19 60 , that I last saw the deceased alive on APRIL 13 , 19 60 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Florence Deringer Joyce M.D.			ADDRESS (Street, city or town, state) WORTON, Md
PHYSICIAN'S NAME (Type) Florence Deringer Joyce		DATE SIGNED 4/14/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-18-60	22c. NAME OF CEMETERY OR CREMATORIAL MORELAND MEM. PK.	22d. LOCATION (City, town, or county) BALTIMORE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Victor J. Kennedy		ADDRESS STILL POND, MD.	24a. REC'D BY REGISTRAR DATE APR 18 '60
			24b. REGISTRAR'S SIGNATURE Charles S. Krause

442 X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4648

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
3. NAME OF DECEASED (Type or print) Emma		First Middle Stradley	4. DATE OF DEATH 4 26 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 1/17/78	9. AGE (In years last birthday) 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Delaware
13. FATHER'S NAME Benjamin Stradley		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (none)	17. INFORMANT Mary L. Caldwell, daughter
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Paroxysm's disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-1, 1960, to 4-26, 1960, that I last saw the deceased alive on 4-25, 1960, and that death occurred at 315 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 4-26-60			
ACTUAL SIGNATURE A.C. Dick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/28/60	22c. NAME OF CEMETERY OR CREMATORIUM Halma Cemetery	22d. LOCATION (City, town, or county) (State) Halma King's Md.
23. FUNERAL DIRECTOR'S SIGNATURE Marvin B. Williams - Chestertown		ADDRESS	24a. REC'D BY REGISTRAR DATE 29 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-troulli permit. Then please remove carbon paper. Pages 1 and 2 should be kept with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4613

Reg. Dist. No.

4655

1. PLACE OF DEATH a. COUNTY Kent				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Delaware			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall (rural)		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linwood		d. STREET ADDRESS 14 Langhead Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Alexander Carrow		First James Middle Alexander Last Carrow		4. DATE OF DEATH April 11 1960		Month April Day 11 Year 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12 1905	
9. AGE (In years last birthday) 54 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Arthur Carrow			
14. MOTHER'S MAIDEN NAME Elizabeth Mooney				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. (If yes, give war or date of service) 180 03 2915				17. INFORMANT Address Mrs Helen Carrow, Chester Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Probable Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) Unusual physical exertion sustained while fighting a DUE TO field fire, Has a history of having had heart trouble (c) and hypertension. Treated in Sacred Heart Hospital							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chester, Pa. for 5 days approximately 3 weeks ago.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Boothwyn Del. Co. Penna.		(County) Boothwyn Del. Co. Penna.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 11 April, 1960							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 15, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Lawncroft Cem.		22d. LOCATION (City, town, or county) Boothwyn Del. Co. Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.			
24a. REC'D BY REGISTRAR Arthur S. Kraus				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
DATE APR 13 '60				DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF SOUTH DAKOTA
STATE OF SOUTH DAKOTA

420.1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

64616

4656

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Near Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Bertha A.				Harris	Apr. 26, 1960			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
female	colored	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 28, 1899	61 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA		
				Kent Co. Md.				
13. FATHER'S NAME Clayton Rochester			14. MOTHER'S MAIDEN NAME Louise Banks					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no			215-26-4458		James Harris Rock Hall, Md.			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
171X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
DUE TO (b) Hypertension			
DUE TO (c) Cordis Vasculor Carcinoma of Cervix			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1960, to April 26, 1960, that (I) (we) last saw the deceased alive at April 26, 1960, and that death occurred at 2 p.m. from the causes and on the date stated above.													
22a. SIGNATURE Norbert C. Nitsch												22b. DATE SIGNED 4/27/60	
22c. PHYSICIAN'S NAME (Type)		Norbert C. Nitsch											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/30/60		23c. NAME OF CEMETERY OR CREMATORIUM Sharptown Cem.		23d. LOCATION (City, town, or county) Mr. Rock Hall, Md.						(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.		250. REC'D BY REGISTRAR APR 29 '60		25b. REGISTRAR'S SIGNATURE C. L. Thorne							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4649 CERTIFICATE OF DEATH

14616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 30 days		2. USUAL RESIDENCE (Where deceased lived. If institut. or Residence before admisn.) a. STATE Maryland		b. COUNTY Kent	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUT. ON Kent & Queen Anne's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville X		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) Cornelius	First	Middle	Last	4. DATE OF DEATH April	Month	21 Day	Year 60
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1872	9. AGE (In years at birthday) 88 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (State or foreign country) Maryland	12 CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Harry Jarvis	14. MOTHER'S MAIDEN NAME Susan Pennington
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 213-22-8412	INFORMANT	Address
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18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 30 days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis		3 years
DUE TO		
C. (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from April 20, 1960, alive on	5-6- 1959	to April 21, 1960, that I last saw the deceased	4:55a.m.	ADDRESS (Street, city or town, state)	DATE SIGNED 4-21-60
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ACTUAL SIGNATURE a. C. Dick	M.D.	Chestertown, Md.
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April, 24, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Galena Cemetery	22d. LOCATION (City, town, or county) Galena, Kent Co.	(State) Md.
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23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows	ADDRESS Wellington, Md.	24a. REC'D BY REGISTRAR DATE APR 25 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4650

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN Tb 45 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS 111	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent + Queen Anne's Hosp.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby		First Bay	Middle Miles	4. DATE OF DEATH April	Month 2	Day 1960	Year
5. SEX male		6. COLOR OR RACE Negro	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH April 2, 1960		8. AGE (In years lost birthday) 45 min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Hauso Miles	
13. FATHER'S NAME Hauso Miles		14. MOTHER'S MAIDEN NAME Dorothy A. Wright					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO —		INFORMANT Hauso Miles		Address Centre St. Baltimore Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.5 DUE TO Convalescence INTERVAL BETWEEN ONSET AND DEATH 10 m							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Congenital Cerebral (c) Pre-maturity 24 weeks 25 m							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1960 to April 2, 1960 , that I last saw the deceased alive on April 2, 1960 and that death occurred at 125 AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Centre St. Baltimore Maryland DATE SIGNED 4-2-60							
ACTUAL SIGNATURE C.R. Layton		M.D.					
PHYSICIAN'S NAME (Type) C.R. Layton							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 2, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Centre		22d. LOCATION (City, town, or county) Baltimore Maryland (State) Burial	
23. FUNERAL DIRECTOR'S SIGNATURE Franklin Smith & Sons		ADDRESS Gulph Mills Md		24a. REC'D BY REGISTRAR SPR 4 '60		24b. REGISTRAR'S SIGNATURE Cathleen S. Hayes	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4657

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 6 & 8 Film C261 4/9/60 ink

Reg. Dist. No. 64618

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL St. Still Pond		c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Jesse	Middle	Last Mills	4. DATE OF DEATH April	Month 4	Day 19	Year 60
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1901	9. AGE (In years last birthday) 65 59 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Del. State Roads		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) no		16. SOCIAL SECURITY NO. 214 30 8676		17. INFORMANT Hattie Cole		Address Still Pond, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Aortic insufficiency				known for one year		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Probable Syphilitic Aortitis				known for one year		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterial Hypertension, Congestive Failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Still Pond, Md.	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 5, 1960		
EXAMINER'S NAME (Type) Robert W. Farr, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/60		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery		22d. LOCATION (City, town, or county) Still Pond, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Victor N. Kennedy</i>		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR APR 6 '60		24b. REGISTRAR'S SIGNATURE <i>Clifford K. ...</i>		
VS. A15ME(5) SM 9/55								

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4658

CERTIFICATE OF DEATH

Reg. Dist. No. 64610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page **1** may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages **1** and **2** should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Betterton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Guy		Middle K.		Last Motter		4. DATE OF DEATH Month April	Day 18	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 9, 1880	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postmaster		10b. KIND OF BUSINESS OR INDUSTRY U. S. Mail		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Isaac M. Motter				14. MOTHER'S MAIDEN NAME Serene Kunkel				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no., or unknown) Yes		16. SOCIAL SECURITY NO. W W I		17. INFORMANT John H. Motter		Address Betterton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Pulmonary & Renal arteriosclerotic Heart Disease								
INTERVAL BETWEEN ONSET AND DEATH 1 hour								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Infarct								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)		
21. I certify that I attended the deceased from <u>8/10/55</u> to <u>4/18/60</u> , 1960, that I last saw the deceased alive on <u>4/10/60</u> , 1960, and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) M.D.								
ACTUAL SIGNATURE Thomas Solon	DATE SIGNED 4-18-60							
PHYSICIAN'S NAME (Type) Thomas Solon	Chestertown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/21/60	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive Cemetery			22d. LOCATION (City, town, or county) Frederick Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy	ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE APR 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

\$20.8

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Towson		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown		d. STREET ADDRESS 109 S. Queen Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 09 S. Queen Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Annie		First	Middle	Last	4. DATE OF DEATH April	Month	Day	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 15, 1879	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Centreville Q.A.Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Thomas Battis		14. MOTHER'S MAIDEN NAME Sarah Catherine Tarbutton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No N/E		17. INFORMANT Mary Elizabeth Starkey		Address 109 S. Queen St. Chestertown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 47 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO Hypertensive Cardiovascular Disease		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, Md., from the causes and on the date stated above. ACTUAL SIGNATURE William M. Entwistle						ADDRESS (Street, city or town, state) Chestertown, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE MAY 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 6-28-60 ams 6-8-60 et 1:4621

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4652 Item 3 Film G264 6-8-60 et
CERTIFICATE OF DEATH
Reg. Dist. No. ✓

1. PLACE OF DEATH a. COUNTY Kent			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN lb 8 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington			d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne's Hospital									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wavva			First Pauline	Middle Thorpe	Lost	4. DATE OF DEATH April	Month 30	Day 19	Year 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1901	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Charles Robinson			14. MOTHER'S MAIDEN NAME Laura Wilson									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Dorothy Alexander (daughter)			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			DUE TO Pulmonary Carcinoma									
(b)			Metastasis			from Carcinoma of Hepatic Flexure of Colon (Resected)						
DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.			20f. (City or town) Chesteranna	(County) Md.	(State) Md.			
21. I certify that I attended the deceased from alive on			to									
ACTUAL SIGNATURE Wm M. Latewood			4/22/60	4/30/60			ADDRESS (Street, city or town, state) Chesteranna, Md.			DATE SIGNED 5/1/60		
PHYSICIAN'S NAME (Type) Burial			22b. DATE THEREOF 5/4/60	22c. NAME OF CEMETERY OR CREMATORIAL Millington Cemetery			22d. LOCATION (City, town, or county) Millington, Maryland	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows			ADDRESS Millington, Md.	24a. REC'D BY REGISTRAR MAY 5 1960			24b. REGISTRAR'S SIGNATURE Arthur S. Hunt					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64622

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 3 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		d. STREET ADDRESS 115 N. Queen Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Johanna		First	Middle	Last	4. DATE OF DEATH 4	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/83	9. AGE (in years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Kent County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Noah Tollinger			14. MOTHER'S MAIDEN NAME Mary Catherine Morris					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		INFORMANT John M. Wright, Son-Chestertown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Kyocarditis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cholecystitis						5 years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 3-30, 1960, to 4-2-, 1960, that I last saw the deceased alive on 4-2, 1960, and that death occurred at 2:10 a.m. from the causes and on the date stated above. ACTUAL SIGNATURE <i>ac dick</i> M.D. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 4-4-60								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/60		22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin B. Williams</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE APR 5 '60		24b. REGISTRAR'S SIGNATURE <i>Orpha S. Frazee</i>		

